

# View

## from the Peak

### EXECUTIVE OFFICER REPORT

*Jenna Bateman*

#### A new home for MHCC

MHCC has moved to new premises. Many of you will be aware that we have been negotiating with the Centre for Mental Health and Central Sydney Area Health Service for some time to secure 'Rose Cottage' situated on the Callan Park / Rozelle Hospital campus. Rose Cottage is a lovely older style free standing building with enough office space for all of us comfortably. Our NGO Development Strategy Officers are no longer crammed into one room struggling to be heard above each other on the phones. We will hold an official opening of the new building possibly as part of our AGM activities. Invitations will go out to all members and friends.



#### NSW State Budget May 24 2005

There is an additional \$71 million on last years mental health spending in the budget bringing the total NSW mental health budget to \$854 million. \$22 million of the additional \$71 million is new money. The rest is funds rolling out from the enhancement of \$241 million over four years announced in 2004. The roll out is slower than anticipated with only \$49 million appearing over 2005 -06.

The new \$22 million has been dedicated to the expansion of Psychiatric Emergency Care (PEC) units and a range of community based mental health projects. Currently there are PEC units at Liverpool and Nepean. These are to be retained and an additional seven units opened over 2005-06 including at St George, St Vincent's and Hornsby hospitals.

The community based mental health projects are targeted to community rehabilitation including: services

for older people, the establishment of specific services for adolescents in contact with the justice system and dual diagnosis and early intervention programs for 16 – 25 year olds. It is unclear how much if any of these funds will flow to NGOs. We do know there is \$8 million being spent on the 3rd stage of the Housing and Supported Accommodation Initiative (HASI) in 2005-06. HASI 3 will target people with high support needs.

The amount budgeted for under 'voluntary organisations' which includes the NGO program along with medical research and universities has been budgeted in 2005-06 at less than revised spending over 2004-05. Mental Health overall in NSW is attracting around 7-8 % of the total health care budget and NGO community based care around 2-3% of the total mental health budget. NSW should be spending more like 15% on mental health services and of this 15% should be funding community based care if NSW is to achieve a balanced and holistic mental health system.

#### Auditor General's Report into Emergency Mental Health Services

Released May 26 2005 this report examines provision of emergency mental health services and makes recommendations on areas for improvement. In 2003-04 there were 24,000 acute admissions representing an 11% increase over the last three years. The report details current problems with access to acute care services particularly after hours; long waiting times in emergency departments for assessment and treatment; poor and inconsistent quality of Area Health call centres and an acute bed rate of 22 per 100,000 which falls below the target of 31 per 100,000. Criticism was also made that distribution of the acute services was inequitable across the state.

*continued end of page 2...*

### ALSO IN THIS ISSUE

Page 2	NGO Development Strategy: update
Page 4	DSP – eligibility bar rises
Page 7	The effect of detention on mental health
Page 8	Advocacy – more questions than answers
Page 12	Public Housing Reform
Page 13	HASI Phase 2

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## NGO DEVELOPMENT STRATEGY: UPDATE

**As many readers will be aware, in August 2004 the Mental Health Coordinating Council commenced the three year NGO Development Strategy. The purpose of the Strategy is to enhance the capacity of NGOs who provide mental health services.**

Since the last newsletter there have been some staff changes amongst the NGO Development Officers. Greg Ford has left to take up a new position and has been replaced by Jane Fisher, who began work at the MHCC in early April. Additionally, Heidi Freeman has returned to work following several months recovering from an accident.

Since January 2005, a draft report outlining the findings of the consultation process and a draft direction paper, outlining tasks to be undertaken in the strategy, have been developed. The strategy has been divided into three project areas:

- **workforce development** including training, governance and wider sector development issues
- **quality and outcomes** promoting the use of quality review systems, outcome measurement and evidence based practice
- **promoting partnerships** focusing on strengthening NGO partnerships with Area Health Services including planning and referral processes.

### Strengthening partnerships

MHCC and the Centre for Mental Health have been working together to develop the NGO Partnership Forum. This Forum aims to promote understanding amongst senior Area Health executives of the range of mental health partnership initiatives underway between human service agencies and the non-government sector. Updates on such initiatives as the Joint Guarantee of Service (JGOS), Housing and Accommodation Support Initiative (HASI) and

the NGO Development Strategy are provided and feedback and advice from Area Health representatives sought.

MHCC presented to the Forum on April 28 progress of the NGO Development Strategy. There was wide ranging debate on funding, training, accreditation and outcome measurements.



*NGO Development Officers:  
Heidi Freeman, Jane Fisher & Sarah Buxton*

### Future directions

In the coming months work on the strategy will consolidate the three program areas by:

- establishing a reference group for workforce development
- developing an options paper on sector training and career pathways
- holding a seminar on outcome measurement for the sector.

If you would like to be on the distribution list for the NGO Development Strategy newsletter please contact Heidi by email on [heidi@mhcc.org.au](mailto:heidi@mhcc.org.au) or 9555 8388. We welcome your interest and comments.

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### EO Report continued from page 1...

The report supports the development of the distinct mental health units within emergency departments (PECs) currently in operation in two hospitals and as noted above, funded in the recently released NSW Budget for establishment in a further 7 hospitals across NSW. The report is very focused on the role of emergency departments in managing acute care and the language of the report is laden with unfriendly management terminology such as 'service block' which refers to the problems people have in receiving timely and appropriate care. The role of the crisis teams is noticeably lacking in terms of any real focus. There is some reference to benefits of co-location of the crisis teams in the new PEC units but it is not a recommendation. The emphasis is on monitoring the service response from the crisis teams wherever they

are most practically located within individual areas. However the acute care community teams as a vital but problematic part of the system have not been adequately reviewed within the report.

The report, while useful, raises the need for the Auditor General to take a similar review / audit of non acute mental health care including non acute inpatient care, community outreach services and the delivery of rehabilitation and support via the non government sector. MHCC is making this recommendation in its response to the Report.

**Best wishes**  
**Jenna Bateman**

## MHCC SEMINAR SERIES 2005 DIALECTICAL BEHAVIOUR THERAPY



*Presenters Judy Campbell and Michelle Meyer at the DBT Seminar with Ann Maclochlainn from MHCC (centre)*

**MHCC having identified the urgent need amongst its members to acquire greater understanding of alternative therapeutic measures for people suffering from personality disorders, responded by holding a full day seminar on Dialectical Behaviour Therapy (DBT) at the Balmain Leagues Club in April 2005.**

The registration response confirmed the huge demand for more information and skill development in this area. To ensure an effective presentation, it was necessary to restrict attendance to 150 persons and we reluctantly had to disappoint many interested people. A broad range of participants from both the government and community sectors attended.

The seminar was presented by two highly experienced and nationally respected DBT therapists and educators, Judy

Campbell and Michelle Meyer, from Wesley Health and Counselling Services. The program outlined was based on skills developed by Marsha Linehan PhD in the USA and adapted to an Australian context.

Clients with personality disorders have great difficulty maintaining constructive relationships. The DBT program aims to break the negative cycle of self-harming and suicidal behaviour, broken therapeutic alliances and frequent hospital admission. A core factor in the success of this form of therapy is the requirement of a long-term commitment on the part of the client, group therapist and individual counsellor, in order to achieve sustainable changes in emotion regulation.

The aim of the seminar was to promote an understanding of personality disorders and the associated problems from the perspective of DBT. Using case studies and role-plays, the presenters introduced participants to the structure of the therapy, the assumptions underlying the approach and demonstrated how DBT can:

- be adapted for use in a variety of settings
- help decrease suicidal and self harming behaviours
- increase interpersonal effectiveness, helping to maintain constructive relationships
- increase distress tolerance and coping skills
- improve the client's ongoing relationships with service providers

Participant evaluations of the seminar were extremely positive and MHCC are considering other ways in which they can improve awareness and advocate for service access and equity in the public sector.

## GRANT AWARDED TO MHCC FOR RESPONSE TO SEXUAL VIOLENCE PROJECT

The NSW Government has awarded a grant of \$15,000 to the Response to Sexual Violence Project (RSVP) under the Victims of Violent Crimes Grants Program. These grants support community based organisations assisting victims of crime and are funded through the profitability of NSW prison industries employing inmates.

The RSVP group have directed their interest since 2003 at the experiences of women who have been sexually assaulted as children, and the long-term effects on their mental health. It was identified that services found it very difficult to meet the needs of this group of women, and their focus centred on barriers to access and equity with regard to treatment and services and the necessity for collaboration between agencies such as mental health, sexual assault, drug and alcohol, housing, counselling, family and forensic services.

This grant will support the Mental Health Coordinating Council in the research and development of a 'best practice' model for access and service delivery to adult survivors of sexual assault in the NGO sector, particularly for those from marginalised groups who experience complex mental health problems and substance abuse. The project will develop a framework contributing to the development of sustainable collaborative services and a State-wide information data base for service providers and users.

**For further information regarding this project, please contact Corinne Henderson at [corinne@mhcc.org.au](mailto:corinne@mhcc.org.au) or (02) 9555 8388.**

# DISABILITY SUPPORT PENSION - ELIGIBILITY BAR RISES

The 2005/2006 Federal Budget has proposed changes to the process of assessment and review for a Disability Support Pension (DSP) and has tightened DSP eligibility by changing the work capacity test from 30 to 15 hours. New income support recipients with a disability will also be subject to all the participation requirements of people without a disability, but with little support to do so.



MHCC agrees that there is the need to bring more people with disabilities of workforce age into employment, but increasing penalties and reducing access to the DSP is not the answer. There is a need to balance obligations with supports, with people having greater barriers to employment needing more support and incentives rather than increased obligations.

## Reduced payments

Recent ACOSS modeling estimates that 60,000 people with disabilities who apply for DSP over the next three years would instead be put on lower unemployment payments. On Newstart Allowance they would be \$20-40 a week worse off than if they were on the DSP. These people would also be required to meet mutual obligation requirements, except for those aged over 55 who will be able to satisfy their participation requirements through voluntary work.

## Assessment

How people apply for eligibility will be one of the fundamental changes to the DSP and processes are yet to be finalised. It has been proposed that GPs will no longer be asked to assess a person's ability to work when applying for a DSP. Rather, GPs would only be asked to supply details of a person's disability and a Centrelink Disability Officer (CDO) would carry out the assessment. MHCC has major concerns about Centrelink being the final arbitrator on DSP eligibility.

## DSP Changes in Detail:

- From 1 July 2006, people assessed as being capable of working more than 15 hours per week at award wages will not be eligible for the DSP.
- People granted the DSP before 11 May 2005 will continue to be assessed against the old rules, unless they leave the pension for more than 2 years, in which case they will be considered new applicants and will be assessed on the new rules.
- People who apply for the DSP between 11 May and 30 June 2006 will initially be assessed on the old rules, but reassessed against the new rules after 1 July 2006
- People who become ineligible to receive the DSP because of earnings will be able to return to the DSP within two years for any reason.

## Penalties

MHCC is also concerned about penalties to be introduced which may impact unfairly on people with a mental illness who may have difficulty managing the requirements. It is proposed that people who do not meet their participation obligations will have their payments suspended until they meet the obligation. People who repeatedly or seriously breach their obligations will have their payment stopped for 8 weeks.

## Allowances

The Mobility Allowance will be increased to \$100 per fortnight for people who are on the Newstart or Youth Allowance and are obliged to look for work or are working more than 15 hours and cannot use public transport. While DSP recipients are registered with an employment assistance provider they will be also eligible for the increased rate of the Allowance.

People with a disability on the Newstart or Youth Allowance will have access to the Pensioner Concession Card, Pharmaceutical Allowance and Telephone Allowance. It is not clear if they will have access to a Health Care Card. They will also be eligible for a once a year Employment Entry Payment of \$312.

People on DSP, the Newstart or Youth Allowance will be able to keep the Pensioner Concession Card for 12

months if they earn enough to lose eligibility for their payment.

### Employment Assistance/Rehabilitation

\$80M over four years will be used to establish Pre-Vocational Participation Accounts to fund assistance that helps people become job ready quickly, such as pain management, work conditioning and short-term mental health interventions. Participation in pre-vocational assistance will be compulsory.

Disability Employment Assistance places (i.e. open employment market) will be increased by 20,000 over 4 years. However, most of these places will be reserved for people with disability who are assessed as being able to work 15 hours or more per week. In addition, the budget includes:

- 137,000 additional Job Network places over 4 years
- 42,000 additional vocational rehabilitation places over 4 years
- 7,600 additional vocational education and training places from July 2006 (subject to Commonwealth, State and Territory negotiations)
- an expanded Language, Literacy and Numeracy Program (by 2,900 places) with additional places targeted at people who have new obligations to work

The Budget contains no measures for Business Services (sheltered workshops).

### Employer Demand Strategy

The Government will work with industry groups and employers to promote better matching of job seekers to employment opportunities, including improving flexible working arrangements and providing increased funding for workplace modifications and wage subsidies.

The Employer Demand Strategy will have three parts:

- targeted and improved industry and workplace engagement strategies;
- training for employers to effectively manage an ageing workforce; and,
- strategies to increase employment of workers with a disability.

A communication campaign will be designed to make employers aware of the benefits of hiring people with disability and other groups. An information service with online support will be established, providing expert advice on workplace adjustments. Tools will be developed to assist employers to address barriers faced by people with mental illness. Key industries to be targeted include hospitality, retailing, manufacturing and building and construction.

*(Details cited Australian Federation of Disability Organisations press release May 2005)*

## DISABILITY PARTICIPATION ALLIANCE

Anticipated government reform of the DSP and employment assistance programs for people with disability has brought the sector together to advocate for positive developments. A new national alliance of disability and welfare organisations has been established and membership is steadily growing. The first forum hosted in February by leading organisations including People with Disabilities (PWD), Australian Council of Social Service (ACOSS), Australian Federation of Disability Organisations (AFDO), National Welfare Rights Network, ACE National Network and ACROD was attended by over 30 disability, welfare and employment services agencies. Options for the reform of income support were discussed, as well as employment policies for people with disability and ways that the community sector could contribute.

A second forum is currently being planned and will be held in Sydney to further the campaign for positive DSP reform.

A second forum is currently being planned and will be held in Sydney to further the campaign for positive DSP reform. The Australian Federation of Disability Organisations (AFDO) is about to launch a campaign about the changes to the DSP and believes there is scope for amendments to the proposed reforms. AFDO believe final decisions on DSP assessment processes are yet to be decided upon and can be influenced by the disability sector through the Alliance.

**The parameters for consultation that the Alliance is calling for are set out in the alliance's 'principles' document which is available on the PWD website: [www.pwd.org.au/alliance](http://www.pwd.org.au/alliance). For more information on joining the Disability Participation Alliance or getting involved in their activities, contact Alanna Clohesy at PWD on 9319 6622 or toll free 1800 422 015**

### INDIVIDUAL ADVOCACY SERVICE People with Disability Australia (PWD)

A free service for people in NSW with a disability who need information, advice or help on a range of issues including: abuse, discrimination, service difficulties, life change. Calls can also be made by family members, carers and disability workers.

Phone Monday to Friday between 1pm and 4.30pm and ask for the Intake Officer or make an appointment for a meeting

Phone: 02 9319 6622  
Free call: 1800 422 015



## HREOC NATIONAL INQUIRY INTO EMPLOYMENT AND DISABILITY

Over the course of 2005, the Human Rights and Equal Opportunity Commission (HREOC) are conducting a national public inquiry on the issues that affect equal opportunity in employment for people with disabilities in Australia. They aim to work constructively with a broad range of parties to develop achievable solutions and practical measures for increasing the opportunities available to people with disabilities in the open workplace.

HREOC has cited statistics that show Australians with a disability have a comparatively lower labour force participation rate (53.2% compared to 80.1%) and a higher unemployment rate (8.6% compared to 5%) than those without a disability. The Inquiry has published a Guide to the Inquiry, as well as four short Issues Papers relating to employment and disability, which can be downloaded from their website on [www.humanrights.gov.au/disability\\_rights/emploment\\_inquiry/index.htm](http://www.humanrights.gov.au/disability_rights/emploment_inquiry/index.htm) While the first round of submissions is now closed there will be further opportunities to make submissions and participate in the Inquiry at later stages.

## EVIDENCE OF GOOD OH&S COMPLIANCE IN THE SECTOR

WorkCover have reported substantial levels of compliance activity and quality OH&S policies across the industry following a recent review of OH&S management systems for client related violence in the community services sector.

ACROD NSW recently led a delegation of disability service managers at a meeting with the DADHC Director-General and senior officers from the WorkCover Authority to seek resolution to tensions between the Occupational Health and Safety Act and the Disability Services Act.

Issues covered at the meeting included findings of the December 2004 audit of non-government accommodation services, compliance issues facing supported employment organisations, issues for attendant care and other in-home support providers, a discussion of WorkCover prosecutions since about 1998, the need for agreed communications protocols between the Authority and the sector and discussion of the current Review of WorkCover Premiums.

The meeting agreed to establish a small working party to draw out and address significant issues identified at the meeting.

ACROD NSW has also made a submission to the WorkCover Authority's Review of Premiums which can be viewed at:  
[www.acrod.org.au/divisions/nsw/PremiumReviewApr05.pdf](http://www.acrod.org.au/divisions/nsw/PremiumReviewApr05.pdf)



## MENTAL HEALTH AWARENESS FOR ATTENDANT CARERS

The Attendant Care Industry Association of NSW Inc (ACIA) held their third training workshop in April 2005 for the attendant care industry, 'Beyond Compliance – from OH&S laws to effective risk management. MHCC were pleased to be invited to present on mental health awareness in community settings. Following a recent needs analysis of the Industry, ACIA have recognised the need for more awareness and support in the area of mental health, ACIA is a recently formed not-for-profit peak body for attendant care providers operating in NSW. Such workshops are ACIA's primary mechanism of sharing information to improve the quality of Attendant Care while representing and advancing the knowledge and practice of service providers in NSW.

Stephanie Maraz from MHCC presented a broad overview of mental illness, possible symptoms and appropriate responses, as well as providing information for training options. She also addressed related Occupational Health and Safety (OH&S) issues with advice for formulating appropriate policies and procedures. The workshop was attended by over 100 attendant carers, supervisors and managers from a range of health settings. Other presenters addressed a variety of OH&S related issues including current legislation, manual handling, medication administration, effective supervision of staff using risk management principles, as well as legal perspectives on balancing risk.

THESE ARE EXCERPTS FROM THE PAPER:

## Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia

In 1992, the Australian Federal Government passed legislation enforcing the mandatory detention of all persons arriving in Australia without valid entry documents. Since then, a significant number of asylum seekers and their children have been held in detention for considerable periods of time.

Concerns have been raised widely and repeatedly about the psychological status of persons held in detention. Systemic study of the mental health status of detained asylum seekers has been hampered by problems in accessing detainees; hence only limited data is available. Thompson and colleagues, in a survey of 25 detained Tamil asylum seekers held at an urban detention centre during 1997 and 1998, found that detainees exhibited high levels of depression, post-traumatic stress, anxiety, panic and physical symptoms compared with expatriate asylum seekers living in the community. Sultan and O'Sullivan, in a participant-observation study, found that 32 of 33 detainees displayed symptoms of major depressive illness with most showing deterioration in their mental state as the length of detention increased.

Sultan and O'Sullivan noted high levels of psychological disturbance among children in detention, but they were unable to investigate the extent of the problem systematically. Nevertheless, the investigators had observed cases of separation anxiety, disruptive conduct, nocturnal enuresis, sleep disturbances, nightmares and night terrors, sleepwalking and impaired cognitive development. Based on clinical impressions, Mares and colleagues also raised concerns that detained children may be at risk of emotional disturbances because of confinement, exposure to violence and self-harm, and the impact of parental distress on care-giving.

The aim of the present study was to document the psychiatric status of a near-complete sample of children and their families from one ethnic group held for an extended period of time in a remote immigration detention facility in Australia. Structured psychiatric interviews were administered by three same-language speaking psychologists by phone to assess the lifetime and current psychiatric disorders among 10 families (14 adults and 20 children) held in immigration detention for more than two years.

Z Steel, S Momartin, C Bateman, A Hafshejani,  
D M Silove - Centre for Population Mental Health  
Research, School of Psychiatry, University of NSW  
N Everson - Refugee Assistance Project  
K Roy - New South Wales Institute of Psychiatry  
M Dudley - School of Psychiatry, University of NSW  
L Newman, B Blick, S Mares - New South Wales  
Institute of Psychiatry

All adults and children met diagnostic criteria for at least one current psychiatric disorder with 26 disorders identified among 14 adults, and 52 disorders among 20 children. Retrospective comparisons indicated that adults displayed a threefold and children a tenfold increase in psychiatric disorder subsequent to detention. Exposure to trauma within detention was commonplace. All adults and the majority of children were regularly distressed by sudden and upsetting memories about detention, intrusive images of events that had occurred, and feelings of sadness and hopelessness. The majority of parents felt they were no longer able to care for, support, or control their children.

All families described traumatic experiences in detention, such as witnessing riots in which guards in riot uniform hit detainees with batons; detainees fighting each other; fire breakouts; detainees publicly committing acts of self-harm; and witnessing suicide attempts. Some items were reported more frequently by children. There were a number of incidents where children, including those under 10 years of age, were separated from their primary care giver(s) for extended periods of time. Children commonly reported distress associated with witnessing acts of self-harm and suicide by other detainees. All children reported boredom, isolation and poor-quality food in detention. They also identified poor access to medical and dental services and counselling.

The rates of psychiatric disorder documented among the 10 families surveyed in the present study are at a level that should raise concern among health professionals, even given the limited sample size. The data obtained should be considered carefully in future policy formulation on the treatment of asylum seekers and may be used by health professions to advocate for the implementation of more humane immigration policies. Alternatives to prolonged detention are available, particularly systems involving bonds, the use of open hostels, and/or the close monitoring of asylum seekers in the community. Flight from oppression, the chief reason for seeking asylum, is associated with distress and psychosocial upheaval. It is essential that in attempting to manage the international asylum crisis, countries with a strong tradition of humanitarian refugee policies do not implement approaches that cause further harm to this vulnerable population.

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The full article can be viewed on the MHCC website: [www.mhcc.org.au](http://www.mhcc.org.au)

# ADVOCACY

For the purpose of exploring some of the emerging issues surrounding the role of 'consumer

→ Sandy Watson

**Q 1. The national standards for mental health services promote consumer participation, and as a consequence, many services have developed a consumer advocacy program. Do you think this has resulted in any confusion with consumer advocacy?**

- YES! 'Consumer advocacy' as a practice, is poorly defined. It is a distinct type of advocacy, but few people have thought this through, or understood its ethical and practical dimensions.
- Most consumer advocates think that their practice is adequately covered by a form of advocacy known as 'Individual' advocacy which is the exact opposite to that which ought to be practised.
- Consumers have no credible industrial award; most are employed as Health Education Officers which leads to confusion because some consumers think of themselves as 'health workers', which they are not.
- Many consumers blur the boundary between advocacy practice, and other practices such as counselling or alternative healing.
- Many consumer advocates breach the rights of the consumers who they are there to protect.
- Some consumer advocates are restricted to being able to undertake 'Systems' advocacy only, which I believe is seriously flawed.
- People mistakenly believe that consumers can't provide advocacy in the same service that employs them. This is not true but advocacy must be designed to be autonomous.

**Q 2. Is it useful to use the term Consumer Consultant for consumer employees of a health service?**

No! Unfortunately this term was used in the first project in Australia (Rozelle) to employ consumers to provide services within the hospital. A Consumer Consultant should be considered to be an external person, brought in to consult, or provide a specific service on the basis that they are external.

**Q 3. What do you think should be the role of a successful consumer advocate and is this the same role as a Consumer Consultant?**

A consumer advocate should be called such, and employed, in a specific advocacy role, with a job description that fits consumer advocacy, and not a whole lot of other irrelevant stuff. In the simplest of terms, a consumer advocate's role is:

- train, support, educate and/or resource consumers to speak up on their own behalf (Self Advocacy)
- raise and act upon systemic issues of concern, that have or may have an unwanted impact on consumers receiving or trying to receive a service (Systemic Advocacy)
- provide an individual advocacy service to a consumer if and when they are unable to advocate for themselves, and they give consent for you to speak on their behalf (Individual Advocacy)
- promote and protect all of the rights of all consumers in the service, without fear or favour
- refer consumers to more appropriate advocacy when necessary
- write timely reports to the issues that arise and get feedback within the service

**Q 4. What consumer advocacy model would you propose?**

In theory, consumer advocacy should operate within every mental health service with an adequate number of working hours, and not be confused with other consumer roles. It should always operate on the basis that three types of advocacy are employed in consumer advocacy: 1. Self, 2. Systems, & 3. Individual (in limited circumstances)

Consumer advocacy needs a clear ethical foundation and performance standards in conjunction with a set of practice guidelines. All advocates should complete the same TAFE accredited skills based training which should be ongoing and mandatory.

→ Phil Escott

With a range of descriptions of our job it is very easy to be confused. We call ourselves consumer advocates, consumer consultants, peer support workers, consumer representatives or consumer workers and there is great variation in job descriptions and consumers' assessment of their role.

When the first service in Australia was set up at Rozelle Hospital in 1993 the word 'consultant' was supported by some to give a positive spin to the job. It was really a play on words referring to the use of phrases such as consultant psychiatrist

## - MORE QUESTIONS THAN ANSWERS

advocacy', three people with backgrounds in this field were asked to respond to the following questions.

and also an attempt to point out the importance of the role. Now it is used to convey the variety and extent of the role, beyond just advocacy.

As the Rozelle group developed it was very much an inpatient service so it was natural that rights issues and on-the-ground advocacy would be central. However, as the National Mental Health Standards stated consumers had a right to be involved in the planning, delivery and evaluation of services at all levels. This implied educational work, representation on committees and having a greater say about the planning of services. It also mandated systems advocacy where big picture issues such as funding levels, staffing and mental health promotion were an important part of the role as well.

Add to this the development of a consumer movement with its own perspective and political objectives and differences and we have the beginnings of a set of problems:

- Can we refer to ourselves as advocates when our roles are much broader? There is no consensus that advocacy is even central to the job.
- Are we taking on too much and forgetting our core business, which to me centres on the promotion of consumer rights and their empowerment.
- Is the consumer consultant role becoming too big and are we forgetting our limitations – the things we can do and realistically the things we can't do?
- Do all of us have a good grasp of the underpinnings of a recovery focus, which to me is central to our work?
- Do we all have the basic standard training to work in inpatient and community settings?
- Can we call ourselves independent advocates when we are also employees of Area Mental Health services? I think Official Visitors have more independence.

Frankly, the number of consumer workers across the State is a little disappointing considering the amount of positive assessment in the literature – no more than 150 workers, most with minimal hours and some services have let go of all their advocates. What we call ourselves does vary and the rhetoric of participation does not match the reality as we struggle with sluggish bureaucracies and an ongoing battle to prove our worth. Perhaps, as a start, we need a national conference to sort out these issues.

### → Janet Meagher

...I'd like to see consumer advocacy move beyond the currently accepted standard to the next level. A level of greater independence that is counterbalanced by a more informed and accredited consumer worker.

After thirteen years of paid consumer advocacy in Australia, there are some real issues emerging; at a local level as well as regionally, across the state and nationally. As to the reason why they are occurring at all, or who, or what, is behind these occurrences is a complex and debatable topic. In this short piece I shall only point to some of the obvious factors and trust that in due course appropriate attention is paid to a more erudite and in-depth investigation into these matters that will point to some ways forward perhaps through comprehensive reform of advocacy programs.

Both Sandy and Phil have raised a number of key issues and pressing matters relevant to a necessary debate on advocacy, including: confusion around the practice and role of advocacy, training needs and time allocation. Debate MUST happen in a sequence that allows all issues to be placed on the table for analysis and discussion, eventually culminating in resolutions and enhanced understanding of advocacy in all its forms in the Mental Health Services and Non Government Sector. My suggested sequence for the debate on consumer advocacy would be as follows:-

1. Consumers critique, discuss and analyse the present situation and circumstances of advocacy as outlined by Sandy and Phil.
2. Consumers involve consumer experts and leaders to inform their discussions, draw up definitions, propose advocacy criteria and agree on role descriptions.
3. Consumers refine ideas, draw up model processes, incorporate definitions into the roles and integrate advocacy criteria and protocols into proposals.

*continued page 10...*

*ADVOCACY continued from pg 9...*

4. Consumers and lead agencies/departments discuss outcomes of steps 1-3 and draw up action plans and proposals.
5. Relevant agencies/departments and stakeholders work on fulfilling action plans, securing any necessary agreements, allocating and drawing up protocols and contracts.
6. Outcomes of the debate would possibly include a scenario something like this:-
  - *Advocacy training* available to consumers in every state and territory. Such training would be:
    - Based on a consumer designed curriculum and syllabus incorporating rights, ethics, empowerment, and other core issues.
    - Presented by experienced qualified consumer tutor/s
    - Accredited, and participants assessed under competency criteria
    - Nationally recognised qualification
    - Paid for by employer [if attending to qualify for existing paid consumer advocacy /consultancy position].
    - Future advocate/consumer consultant positions to require this qualification as an essential criteria for job applicants.
  - Consumer Advocates/consumer consultants to be *employed independently* of a Health Service or Non Government Organization and contracted to the Service (or NGO) for their services.
  - Consistent and agreed National Standards of Consumer Advocacy be established to inform all advocates and stakeholders.
  - Consistent and agreed employment contracts, codes of ethics/ conduct and salary scales being implemented.
  - Advocacy and consumer consultancy be overseen by a national consumer advocacy steering committee.

In summary, I'd like to see consumer advocacy move beyond the currently accepted standard to the next level. A level of greater independence that is counterbalanced by a more informed and accredited consumer worker. This worker will have real opportunities to move through a career structure based on agreed standards of performance and will report in a consumer friendly framework which will lessen the potential to cause conflict or compromises within the role. This will enhance relationships with the contracted service or organisation and enable the consumer worker to more readily comply with the consumer's agreed Codes of Ethics. Let the debate commence!

*N.B. These comments are made by the respondents as independent people, and are not made on behalf of any organisation or group.*

**If you would like to continue this debate please write with your comments to the Editor at [Stephanie@mhcc.org.au](mailto:Stephanie@mhcc.org.au)**

## SUPPORTING PEOPLE WITH A MENTAL ILLNESS AT WORK

One of the biggest challenges for people with mental illness is finding and maintaining employment, which prompted SANE Australia to produce a much-needed resource for employers and staff to support co-workers with a mental illness. 'The SANE Guide to Mental Illness for the Workplace' offers information about mental illness and practical advice on how to support a colleague with mental illness. Research shows that employment is one of the most effective ways to help people with mental illness by providing income and the dignity of a place in the community.

The availability of the Guide is timely given research has found that over two-thirds of people with a psychiatric disability would like to be in some type of employment. According to recent figures released in the Job Network Disability Support Pension Pilot: Interim Evaluation Report, participation in work was reported by Pilot participants to have positive financial benefits (57%), to contribute positively to self-image and self-worth (42%) and to enhance community inclusion (32%). This is particularly so for people with psychiatric disability.

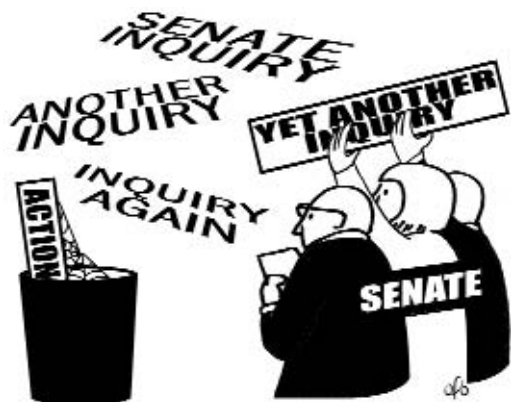
**To obtain copies of The SANE Guide to Mental Illness for the Workplace, visit [www.sane.org](http://www.sane.org) or phone 03 9682 5933.**

## MEDICATION AND TREATMENT GUIDE FOR MENTAL ILLNESS

SANE Australia recently released The Sane Guide to Medication and Other Treatments which will help take some of the confusion out of medical care for mental illness. Treatment of mental illness can be a complex business. The SANE Guide explains how all the different aspects of treatment work, so that the best possible benefit can be drawn from it.

**The guide is available for \$9 plus p&h. to obtain a copy, visit [www.sane.org](http://www.sane.org) or phone 1800 688 382**

## SENATE TAKES ANOTHER LOOK AT MENTAL HEALTH CRISIS



The crisis in mental health services in Australia will be investigated by the newly established Senate Select Committee on Mental Health, chaired by Democrat Leader Senator Lyn Allison with a report due by 6th October 2005. The Committee will investigate the provision and adequacy of mental health services in Australia, and will be particularly referring to the Commonwealth's National Mental Health Strategy. The inquiry was spurred on by the case of Cornelia Rau, an Australian resident with a mental illness who spent 10 months in immigration detention after authorities failed to identify her schizophrenia. The inquiry has since been widened to examine the case of Australian woman Vivian Alvarez, who was deported to the Philippines in an immigration department bungle.

MHCC has made a submission to the Inquiry addressing a range of key issues which highlight major service gaps and a widespread dissatisfaction with mental health services. We have stressed the need for more resources in the community and a greater emphasis on facilitating rehabilitation as well as acknowledging the importance of the availability of in-patient beds for acute mental health care.

Other issues addressed include the need for:

- a "whole-of-government" approach to mental health service provision
- expanded early-intervention programs, interagency collaboration of community services or the co-management of people with complex needs
- consumer and carer participation at all levels of policy, planning, treatment and recovery
- equitable access to services for people with a mental illness who encounter the criminal justice system
- attention to education and training programs for GPs to emphasise long-term functional outcomes
- enhanced services to rural and regional areas
- investment in medical research and innovation

**The MHCC submission is accessible on our website: [www.mhcc.org.au](http://www.mhcc.org.au)**



### MHCA MEETING CHANGE AND CHALLENGE

Mr John Mendoza this year was appointed the new Chief Executive Officer for Australia's national independent peak mental health body, the Mental Health Council of Australia (MHCA). Mr Mendoza comes to the position after 4 years as CEO of the Australian Sports Drugs Agency where he gained extensive experience in the development of alliances aimed at improving the quality and continuity of health care. We hope the respect and confidence he has earned from leaders in public health reform will be translated in his new promotional efforts for the mental health sector.

MHCA have been busy working on the National Report on Mental Health and Human Rights which will reveal the stories of hundreds of distressed and anguished Australians who have been in contact with the mental health system. The report is in its final stages and MHCA believe it will increase community concern and gain widespread media coverage.

The Council continues to actively monitor and respond to other cases relevant to the Inquiry into the Cornelia Rau affair which has now been widened since the revelation that at least one other Australian has been deported overseas and remains missing. The Council has met with

Mr Palmer, the man heading the Inquiry, to relay the sector's concerns and provide advice and have called for an open judicial inquiry.

John Mendoza has met with the Minister, Kevin Andrews to discuss his concerns about the possible impact of disability support payment (DSP) reforms on people with a mental illness. The Council remains actively engaged with Government on the reform process. The Council has also prepared a high powered submission to the Senate Inquiry into Mental Health in consultation with MHCA Members. The Inquiry is due to report in October.

The National Mental Health Working Group, of which MHCA is a member, continues to monitor the painstakingly slow implementation of the 2003-2008 National Mental Health Plan and Policy. At their last meeting MHCA called for real actions and a clear comprehensive set of performance measures and reporting requirements. They also pressed for accountability with public reporting and real budget measures as an appropriate percentage of the health budget which should be ready for adoption at the next working group meeting in July.



## PUBLIC HOUSING REFORM

The Carr Government has announced that it will end security of tenure and increase rents in public housing. If implemented, the proposals will place all new tenants on fixed term leases, some as short as two years, and terminate their tenancies at the end of the fixed term if their incomes have risen above new eligibility thresholds. The plan aims to free up housing by encouraging people on what it calls "moderate" incomes to move into private accommodation. The rent for people in this group, whose incomes start at \$29,000 a year after tax, will increase by 20 per cent from November.

The Carr Government has announced that it will end security of tenure and increase rents in public housing.

There are about 350,000 tenants in 145,000 public housing properties across the state, with a further 71,000 people on waiting lists. The proposed changes will affect about a third of the tenants, lifting their average rent by \$15 to \$88 a week. Additionally, tenants will soon be charged for their water use which will incur a bill of about \$5 each week. The Government plans to use the extra funds as part of a \$2.7 billion plan to build or buy 12,000 homes, refurbish another 8000 homes and modify a further 10,000 homes to suit people with disabilities.

Currently, tenants may remain in public housing as long as they abide by their lease. As their income increases, and they pay an increased rent which subsidises the operation of the public housing system. From July 2005 the Department will offer one-year leases to all new tenants and on the expiry of those leases they will be offered fixed term leases in line with the new policy, if they are eligible. The Tenants Union believes the whole public housing system will suffer as a result of the policies announced. While it is correct that funding cuts by Federal Government have seriously undermined the viability of the public housing system, the current proposals verify the continuing decline and marginalisation of public housing in New South Wales.

## ACCEPTABLE BEHAVIOUR AGREEMENT PILOTS UNDERWAY

Pilot studies are now underway for the Acceptable Behaviour Agreement (ABA) legislation brought into force in December 2004. The legislation will enable the Department of Housing to enter into ABAs with tenants who are alleged to be engaging in anti-social behaviour. While the DoH have worked hard to develop a policy framework ensuring people with a mental illness will receive a proper assessment placing them outside the ABA regime, concerns remain about the reality of working within this new regime.

The six month pilots are currently being held in Wagga Wagga and Newcastle with a full evaluation of the implementation of these measures to follow after 12 months of operation. Meanwhile the DoH are visiting agencies in the pilot areas and seeking support for a cross government approach to the ABA and encouraging client sharing and appropriate referral as required in line with best practice guidelines.

MHCC is also pleased to report that the DoH are providing mental illness awareness education for staff to support the policy guidelines. The training will also promote an improved responsiveness from DoH staff to people with a mental illness who may have unmet needs for health and social services.

## CONSUMER AND CARER PARTICIPATION GUIDELINES

The Consumer and Carer Participation Policy: A Framework for the Mental Health Sector has been developed by the National Consumer and Carer Forum (NCCF) as a guide that can be used by all participants involved in mental health, within the public, private and non-government sectors.

NCCF stress the importance of mental health consumers and carers participating in decision making at all levels concerning the mental health services that affect their lives. NCCF is a national initiative operating under the auspice of the Mental Health Council of Australia (MHCA) and aims to progress consumer and carer participation in the mental health sector.

The document is intended as an example of best practice in the development and/or implementation of consumer and carer participation policies. **For copies of the policy contact [admin@mhca.com.au](mailto:admin@mhca.com.au) or download from MHCA website [www.mhca.com.au](http://www.mhca.com.au) under 'Publications'.**

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## HOUSING AND ACCOMMODATION SUPPORT INITIATIVE – PHASE 2

The NSW Government today announced a \$13.8 million program to provide disability support to 460 people with a mental illness over 3 years. The Housing and Accommodation Support Initiative (HASI) is now in the second phase of a joint initiative between NSW Health, Housing and the NGO sector that commenced in 2002. HASI 2 will provide low Support Outreach services and tenders are funded till 30th June 2008.



Under this program NSW Health provides the clinical support while the NGO sector provides the non-clinical support that assists people to function in their daily lives while living in the community. The Department of Housing provides the accommodation.

MHCC was part of an independent panel with NSW Health, the Department of Housing, and the NSW Consumer Advisory Group which provided assistance in the evaluation of tenders.

HASI Stage 2 will be implemented across all Area Health Services reaching out to metropolitan and regional NSW. The successful applicants are listed here with details of areas and the number of packages.

### **Mission Australia** - 110 packages:

Greater Western Area Health (Far West and Macquarie Service); North Coast Area Health Service (Northern Rivers and Mid-North Coast); and one part of Northern Sydney Area Health Service (Northern Sydney).

### **Psychiatric Rehabilitation Association (PRA)** – 90 packages:

Greater Southern Area Health Service (Southern Area and Greater Southern); and Hunter/New England (Hunter and New England)

### **NEAMI** - 105 packages:

One part of Sydney South West Area Health Service (South Western Sydney); and South Eastern Sydney Illawarra Area Health Service (South Eastern Sydney and Illawarra).

### **Parramatta Mission** - 40 packages:

One part of Sydney West Area Health Service (Western Sydney).

### **Aftercare** - 80 packages:

One part of Sydney South West Area Health Service (Central Sydney); and One part of Sydney West Area Health Service (Wentworth).

### **New Horizons** - 30 packages:

One part of Northern Sydney/Central Coast Area Health Service (Central Coast).

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## SUPPORTED ACCOMMODATION CONSULTATION

The Department of Ageing Disability and Home Care (DADHC) recently released a discussion paper on Models of Supported Accommodation for People with a Disability and have sought feedback from interested stakeholders. The intention is to generate policy directions for the diversification of supported accommodation models to enable DADHC to meet the needs of a broad spectrum of people with disability who require this support.

“...true value will be found in appropriate placements  
to suit individual needs and preferences.”

While all the models outlined in the paper held merit, their true value will be found in appropriate placements to suit individual needs and preferences. MHCC also proposed an additional model to address the substantial need for suitable accommodation options and services for clients with very high needs and challenging behaviours.

Other comments included the importance of:

- a focus on client needs and the reassessment of needs on that basis
- productive partnerships between Health, Housing and NGOs
- a mix of staff skills to meet the needs arising from psychiatric disability
- addressing the gap between funding levels and the needs of the ageing population

The MHCC submission is accessible on our website: [www.mhcc.org.au](http://www.mhcc.org.au)

## NEW MENTAL HEALTH COURSE THROUGH OTEN

The Open Training and Education Network (OTEN) of Western Sydney Institute, TAFE NSW is developing a Certificate IV in Mental Health Work (Non-Clinical) and a Statement of Attainment in Mental Health Work (Non-Clinical), to be offered by distance education in Semester 1, 2006.

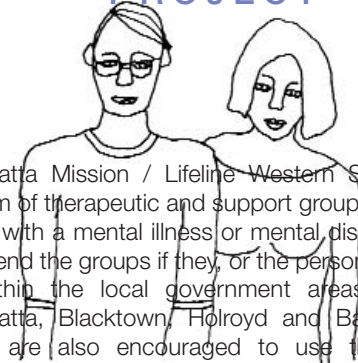
The Statement of Attainment will allow graduates to undertake up to five modules from the Certificate IV. Students wishing to further their studies can then claim recognition of prior learning towards gaining a Certificate IV.

Many of the modules offered can also be accredited to other community services training packages such as Alcohol and Other Drugs Work. These courses will be of value for staff from both mental health and non-mental health organisations.

The course will give students a nationally recognised qualification, allow them the flexibility to study when and where it suits them and is reasonably priced.

**For further information you can contact David McKenzie at OTEN on 02 9715 8541 or email [david.mckenzie@tafensw.edu.au](mailto:david.mckenzie@tafensw.edu.au)**

## CARE FOR CARERS PROJECT



Parramatta Mission / Lifeline Western Sydney has a program of therapeutic and support groups for carers of people with a mental illness or mental disorder. Carers can attend the groups if they, or the person they care for live within the local government areas of Auburn, Parramatta, Blacktown, Holroyd and Baulkham Hills. Carers are also encouraged to use the telephone counselling service provided by Lifeline Western Sydney for back up support. Phone: 13 11 14

### Objectives:

- Focus on the needs of the carer
- Flexible with group content and based on need
- Enhance skills to manage feelings of grief, guilt, anxiety and depression
- Reduce social isolation
- Enhance relationships and communication between the carer and their partner with a mental illness
- Assist in establishing formal and informal support networks

### Contact Details:

David Josephson, Lifeline Western Sydney  
(02) 9891-6212 or [davidj@lifelinews.org.au](mailto:davidj@lifelinews.org.au)

## COMMUNITY INTEGRATION IN NZ

Two workers from an Auckland based organisation, TeKorowai Aroha, part of Baptist Action, visited MHCC recently, as part of a study tour. Monika Divis and Kayte Ferguson work with the social and recreation community outreach team, on the Kokiri Ka Taea program (Maori translation: Go forth and achieve). Their study visit, to organisations in NSW and Victoria, was to look at ways of supporting effective community integration for those living with mental illness.

Their work involves facilitating group programs aimed at 'strengthening and encouraging wellness in the community', using the Charles Rapp Strengths Model. Workshops are held to introduce people to this model, which works by focusing on people's strengths and interests, and uses the wider community to help each person reach their goals.

A key principle is that all people experiencing a mental illness are able to learn, grow and change. People are able to learn new skills, build on strengths, meet new people, and strengthen old friendships. Groups include supported employment (assisting people to find paid mainstream employment), a wellness recovery action plan group (a personalised plan that assists people to manage uncomfortable symptoms), a walking group, and a movie group.

**Further information can be obtained from:**  
**[www.baptistaction.org.nz](http://www.baptistaction.org.nz)**  
**email: [Monika.divis@tekorowaiaroha.org.nz](mailto:Monika.divis@tekorowaiaroha.org.nz)**

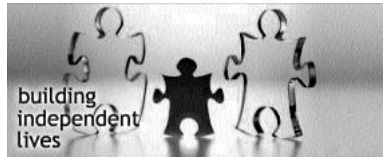
## MEDICAL RESEARCH INTO SCHIZOPHRENIA CONTINUES

An international team, led by NISAD schizophrenia researchers in NSW, has shown a direct link between structural differences found in the brains of people with schizophrenia and some of the core features of the illness.

The discovery was made using advanced technology that allowed for a direct comparison of the thickness and function of the brain in 10 young patients with early onset schizophrenia while they performed a planning task involving attention and working memory in an MRI scanner. Whilst a healthy control group completed the test with relative ease, the patients with schizophrenia had difficulty. The computer analysis of their brains was able to show that their impaired thought processes and inability to problem-solve (key features of schizophrenia) were directly related to the reduced grey matter thickness and reduced activity of the affected part of the brain. NISAD believes the findings will trigger a new raft of studies, which may lead to novel interventions aiming to prevent schizophrenia. For more information visit: [www.nisad.org.au](http://www.nisad.org.au)

While MHCC believes that speculation into the cause of schizophrenia is important, resources for improving the quality of life of people with a mental illness must also be a priority.

## AFTERCARE

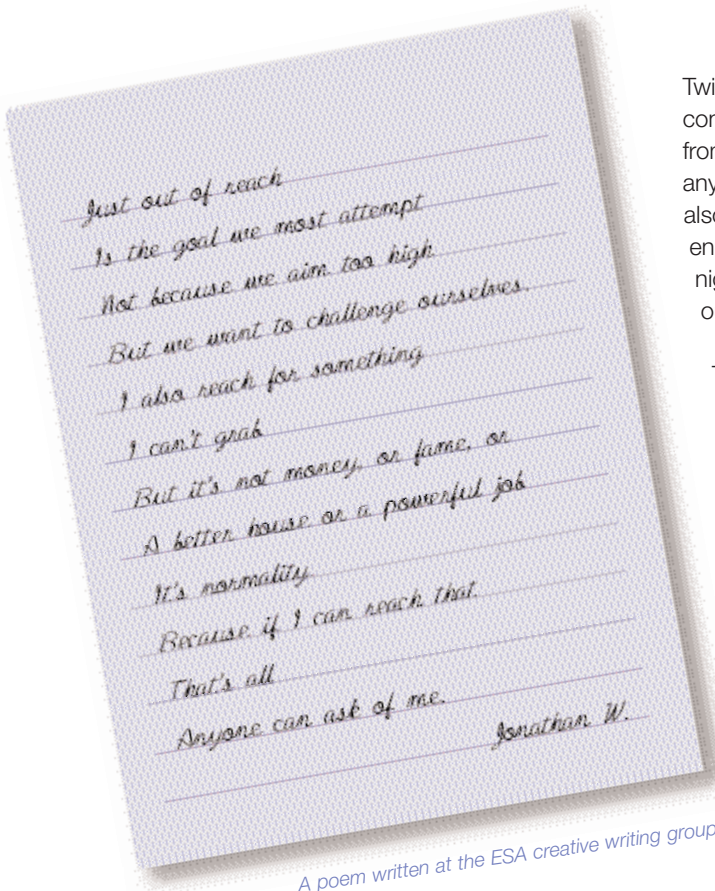


AFTERCARE was established in 1907 with the aim of assisting individuals who were suffering from a mental illness and/or intellectual disability to return to the community. It is one of the longest serving, non-government organisations in the State offering support and accommodation to people with a mental illness and/or intellectual disability. The aims of Aftercare have changed little since 1907 however the way in which we build independent lives has changed to meet the needs and requests of the people using the service. The services provide individually tailored programs for people.

AFTERCARE has various program areas. One of these is Eastern Suburbs Aftercare (ESA). ESA operates in the eastern suburbs of Sydney providing services for people who suffer a mental illness. ESA offers social, recreational and leisure activities which are run in the local community. We provide a wide variety of activities in our program which are determined through consultation with our consumers. Some of the groups currently running include: a creative writing group, an acting group, an art group, a yoga group and a fitness group. We also have a social chat group which meets once a week in a local café. Once a month we hold a consumer/staff meeting to get feedback from consumers about the service and any suggestions of ways to improve it. Every 3 months we produce a new program together with a newsletter which includes consumer's poems and stories and details of upcoming events.



ESA consumers and staff enjoying their Christmas party last year



A poem written at the ESA creative writing group

Twice a year we have a 'Performance Night' where consumers from the acting group perform a play, those from the writing group read their stories and poems and anyone who feels inclined can get up and sing a song. We also display the artwork from the art group. Everyone is encouraged to invite their family and friends, and these nights have proven to be a popular and inspiring event on our calendar.

The main benefits experienced by those who participate in the ESA program are: the development of new skills e.g. creative writing, art, communication, an increased confidence and self-esteem, and the making of friends and socialising. For people who wish to take part in our program, they can contact their case manager and ask them to fill in a referral form. If they don't have a case manager they can ask their GP, psychiatrist, or area health service to fill in the referral form.

If anyone wishes to contact ESA they can phone any staff member on 93989738.

## JUNE 2005

### Empowering Individuals and Families in the Human Services

Exploring an agenda of empowerment for individuals and families in the fields of disability, mental health, aged care, youth, schools, health care and family support.

**When:** 17 June 2005

**Where:** Y on the Park Conference Centre, 5-11 Wentworth Ave, Sydney

**Further info:**

<http://www.partnerships.org.au/Empowering2005.htm>

### Challenging Depression in the Elderly, National Conference 2005.

**When:** 23 – 24 June 2005

**Where:** The Footbridge Theatre, University of Sydney

**Further info:** [www.hammond.com.au/conference](http://www.hammond.com.au/conference)

Ph: 02 9825 5081 or [mandrew@hammond.com.au](mailto:mandrew@hammond.com.au)

## JULY 2005

**Shelter NSW- Housing dollars, social value:** the social and economic outcomes of public and community housing

**When:** Tuesday 5 July 2005

**Where:** Architecture Lecture Theatre, Wilkinson Building Sydney University

**Further info:** Ph (02) 9267 5733 or

[www.shelternsw.org.au/docs/fly0507sem-rego.html](http://www.shelternsw.org.au/docs/fly0507sem-rego.html)

### 2nd National ACROD Ageing & Disability Conference

**When:** 18-20 July 2005

**Where:** Hotel Grand Chancellor, Hobart, hosted by the Tasmanian Division of ACROD

**Further info:** Convention Wise, Phil Holmes,

Ph: 03 6234 1424 or [www.conventionwise.com.au](http://www.conventionwise.com.au)

## AUGUST/SEPTEMBER 2005

### TheMHS 15th Annual conference Dancing to the Beat of a Different Drum

**When:** 30 August – 2 September

**Where:** Adelaide Convention Centre, South Australia

**Further info:** <http://www.themhs.org>

### The 6th International Mental Health Conference - 'What's New In Mood Disorders'

**When:** 2nd – 4th September

**Where:** Conrad Jupiters, Gold Coast

**Further info:**

<http://www.gcimh.com.au/conference/Default.htm>

NGO  
Development  
Strategy

**mhcc**  
...building strength  
and quality

MHCC NGO DEVELOPMENT STRATEGY

OUTCOME MEASUREMENT:  
MAPPING THE  
DIFFERENCE WE MAKE

Mental health outcomes  
in the NGO sector

**Date:** Friday 22 July 05

**Time:** 9.00am – 4.30pm

**Location:** Petersham RSL  
7a Regent St  
Petersham, Sydney

**No Cost:** Lunch available for \$5 from  
Bistro on site

*\*Disabled access \*Free Parking  
\*Close to Petersham Train Station*

#### A strategic discussion with MHCC members:

- To consider the principles and value of the use of outcome measurement in the context of NGOs working in mental health
- To understand current practice around outcome measurement in both public and NGO sectors, models and tools used, and the evidence base
- To reflect with others on the pressure for a standardised approach to using outcome measures in the NGO sector

**For flyer and registration form contact**

[info@mhcc.org.au](mailto:info@mhcc.org.au) or phone 02 9555 8388



Working for  
Mental Health

The Mental Health Coordinating Council is the peak body for non-government organisations working for mental health in New South Wales.

For information about membership, contact MHCC on (02) 9555 8388.

## MHCC STAFF AND CONTACT DETAILS

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